

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Carroll

446

Village or City Harrison Bridge (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 81St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Stirling Grant Baker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single6 DATE OF BIRTH Jan. 8

(Month)

(Day)

(Year)

7 AGE 1 week. 6 day

Yrs.

mos.

ds.

If LESS than  
1 day,.....hrs.  
OR.....min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer) 100

## 9 BIRTHPLACE

(State or country) Carroll

## 10 NAME OF FATHER

Grant Baker

## 11 BIRTHPLACE OF FATHER

(State or country) Carroll

## 12 MAIDEN NAME OF MOTHER

Wuthilda Angell

## 13 BIRTHPLACE OF MOTHER

(State or country) Carroll

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse Fales(Address) Harrison Bridge

15

Filed Jan 22, 1915T. H. Lester

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

89

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 22

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1915 to Jan. 22, 1915, that I last saw him alive on Jan. 22, 1915 and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) J. H. Lester, M. D.  
Jan. 22, 1915 (Address) Harrison Bridge, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL Harrison BridgeDATE OF BURIAL Jan 22, 191520 UNDERTAKER Bankard & Wadsworth

## ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal minc*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tecnus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 4 1915

BUREAU, V.S.

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1 PLACE OF DEATH  
County *Carroll* 447

Village or City *Finksburg* (No.)

2 FULL NAME *John Webster Barnes*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married* (Write the word)

## 6 DATE OF BIRTH

*Jan* 28, 1841  
(Month) (Day) (Year)

## 7 AGE

*23 yrs 2 mos 21 ds.* If LESS than 1 day, hrs. OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work *Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

*Maryland*  
10 NAME OF FATHER *Robert Barnes*

11 BIRTHPLACE OF FATHER  
(State or country)

*Maryland*  
12 MAIDEN NAME OF MOTHER *Elizabeth Smith*

13 BIRTHPLACE OF MOTHER  
(State or country)

*Maryland*  
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(informant) *Murtha A Barnes*  
(Address) *Finksburg*

15

Filed *Jan 29, 1915* by *John Lester*

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *73*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*Jan* 28<sup>th</sup>, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

*Jan* 27, 1915, to *Jan* 28<sup>th</sup>, 1915  
that I last saw him alive on *Jan* 28<sup>th</sup>, 1915

and that death occurred on the date stated above, at \_\_\_\_\_.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(Duration) yrs. *1* mos. *1* ds.

Contributory *Arterio-Sclerosis*  
Secondary

(Duration) yrs. *1* mos. *1* ds.

(Signed) *John Lester*, M. D.

*Jan 29, 1915* (Address) *Armbler*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Smallwood* *Jan 31, 1915*

## 20 UNDERTAKER ADDRESS

*Frank C. Barnes Undertaker*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma

"

cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Complaint"), "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 8 1915

BUREAU, U. S.

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1 PLACE OF DEATH		448
County	Carroll	
Village or City	Taylorsville, (No. 120)	
2 FULL NAME Margaret L. J. Barnes		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	white	Married
6 DATE OF BIRTH		
Nov. 7 <sup>th</sup>		, 1864 (Month) (Day) (Year)
7 AGE		
50 yrs.	2 mos.	14 ds.
8 OCCUPATION		
(a) Trade, profession, or particular kind of work.		
Housewife		
(b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country)		
Maryland		
10 NAME OF FATHER		
James S. Barnes		
11 BIRTHPLACE OF FATHER (State or country)		
Maryland		
12 MAIDEN NAME OF MOTHER		
Julia Ann Stein		
13 BIRTHPLACE OF MOTHER (State or country)		
Maryland		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) James S. Barnes		
(Address) R. F. #4 Mt. airy Md.		
15		
Filed Jan. 23, 1915. J. A. Farmer, Local REGISTRAR		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 78

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH		
Jan	21 <sup>st</sup>	, 1915 (Month) (Day) (Year)
17 I HEREBY CERTIFY, That I attended deceased from		
Mar 1915, to Jan 21 <sup>st</sup> , 1915.		
that I last saw her alive on Jan 21 <sup>st</sup> , 1915.		
and that death occurred on the date stated above, at 9:45 A. m.		
The CAUSE OF DEATH* was as follows:		
Caluonia Enteric Nephritis		
(Duration) One yrs. mos. ds.		
Contributory Accidents and Diseases		
Secondary		
(Duration) One yrs. mos. ds.		
(Signed) A. T. Guards, M. D.		
Jan 22 <sup>nd</sup> , 1915. (Address) Mt. airy		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
At place of death yrs. mos. ds.		
In the State yrs. mos. ds.		
Where was disease contracted, if not at place of death?		
Former or usual residence.		
19 PLACE OF BURIAL OR REMOVAL		
Taylorsville M. C. Cemetery, Jan. 24 <sup>th</sup> , 1915		
DATE OF BURIAL		
20 UNDERTAKER		
C. M. Wall, Winfield, Md.		
ADDRESS		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasms*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County. Danville

449

Village or City Greenmount (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 77

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

79  
Mary C. Bell

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, DIVORCED  
(Write the word) widow

6 DATE OF BIRTH Lees 12, 1847  
(Month) (Day) (Year)

7 AGE 67 yrs. 1 mos. 12 ds. If LESS than 1 day, .... hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF FATHER Jacob Shaffer

11 BIRTHPLACE OF FATHER  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Shickler

13 BIRTHPLACE OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Edward S. Tipton

(Address) Hampstead Md

15 Filed Jan 25, 1915 by John Abbott

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 24, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

January 2, 1915, to January 22, 1915,

that I last saw her alive on January 22, 1915,

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH\* was as follows:

Valvular Heart Disease

Diabetes (Duration) yrs. mos. ds.

Contributory  
Secondary

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
(Signed) Edward S. Tipton, M. D.

1/24, 1915 (Address) Hampstead

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 PLACE OF BURIAL OR REMOVAL Greenmount Md DATE OF BURIAL 1-26, 1915

20 UNDERTAKER C. O. Tipton & Son ADDRESS Hampstead Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

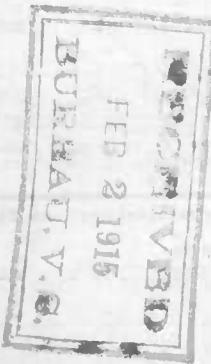
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## Statement of cause of death

Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

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BUREAU, V. S.

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1 PLACE OF DEATH  
County Carroll.

450

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 78

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Demarest (No. \_\_\_\_\_)2 FULL NAME Stillborn. (Bloom)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Jan 22, 1915  
(Month) (Day) (Year)

7 AGE

..... yrs. .... mos. .... ds. IT LESS than  
1 day, .... hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Carroll Co

10 NAME OF FATHER

Halley Bloom.11 BIRTHPLACE OF FATHER  
(State or country)Frederick Co

12 MAIDEN NAME OF MOTHER

Maggie F. Tucker13 BIRTHPLACE OF MOTHER  
(State or country)Carroll Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father(Address) Westminster

15

Filed Jan 22, 1915 Jack Farmer  
Seal REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 22, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 22, 1915, to Jan 22, 1915, 1915  
that I last saw h. alive on

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Stillborn  
.....  
..... (Duration) yrs. mos. ds.

Contributory  
Secondary

..... (Duration) yrs. mos. ds.

(Signed) A. T. Paul, M. D.

Jan 22, 1915 (Address) Altamay

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Demarest Jan 22, 1915

20 UNDERTAKER ADDRESS

C. W. Kelly Westminster

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The matrarial worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*



oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Carroll

451

1136

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 26

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Westminster (No.)2 FULL NAME Susan Bowersox

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u> (Write the word)
---------------------	------------------------------	--

6 DATE OF BIRTH Jan 12, 1891  
(Month) (Day) (Year)

7 AGE 84 yrs. 7 mos. 7 ds.  
If LESS than  
t day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work At home  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF  
FATHER Benjamin Fowler

11 BIRTHPLACE  
OF FATHER  
(State or country) Maryland

12 MAIDEN NAME  
OF MOTHER Catharine Crowell

13 BIRTHPLACE  
OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nannie Bowersox

(Address) Westminster, Md.

15 Filed Jan 19, 1916 — E. W. House

REGISTRAR

79

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 19, 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1916, to Jan 18, 1916,

that I last saw h. s. alive on Jan 18, 1916,

and that death occurred on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH\* was as follows:

Heart disease

(Duration) 6 mos. 17 ds.

Contributory Same  
Secondary

(Duration) 0 yrs. 6 mos. 17 ds.

(Signed) Jas. H. Billingsley, M. D.  
Jan 19, 1916 (Address) Westminster, Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Westminster DATE OF BURIAL Jan 22, 1916

20 UNDERTAKER Frank C. Sharrer ADDRESS Westminster

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laboret," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc. of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranquillity," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, U. S.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second line statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Clothing*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, etc. who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the ~~disease~~ causng death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the ~~disease~~ causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typholdd pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, periosteum*, etc. *Carcin-*

oma, Sarcoma, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Miasma," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**Statement of cause of death**—Name, first, the ~~disaster~~ cause of death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*; *Carcin-*

RECEIVED  
FEB 6 1915

FEB 6 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

453

County Carroll

79

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Sykesville (Not Springfield, State Md. St. ~~Springfield~~)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emilia Frances Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
---------------------	------------------------------	--

6 DATE OF BIRTH <u>Unknown</u>	(Month)	(Day)	(Year)
--------------------------------	---------	-------	--------

7 AGE <u>7</u>	8 LABOR <u>House</u>	9 If LESS than 1 day, hrs. OR min. ?
Yrs. <u>7</u>	Mos. <u>0</u>	ds. <u>0</u>

10 OCCUPATION <u>House</u>	11 BIRTHPLACE <u>Maryland</u>
(a) Trade, profession, or particular kind of work.	(State or country)
(b) General nature of industry, business, or establishment in which employed (or employer) <u>House</u>	

12 BIRTHPLACE <u>Maryland</u>	13 MAIDEN NAME OF MOTHER <u>"</u>
(State or country)	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE <u>Hospital Records</u>	15 (Address) <u>Sykesville, Md.</u>
--	-------------------------------------

16 (Informant) <u>Hospital Records</u>	17 (Address) <u>Sykesville, Md.</u>
--	-------------------------------------

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) <u>Unknown</u>	19 PLACE OF BURIAL OR REMOVAL <u>Washington DC</u>
--	--

At place of death yrs. <u>0</u> mos. <u>0</u> ds. <u>0</u>	20 DATE OF BURIAL <u>Feb 2, 1915</u>
--	--------------------------------------

Where was disease contracted, if not at place of death? <u>Unknown</u>	21 UNDERTAKER <u>Gas R. Weer</u>
--	----------------------------------

Former or usual residence. <u>Prince George Co., Md.</u>	22 ADDRESS <u>By Reserve</u>
--	------------------------------

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 31, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1915 to Jan. 31, 1915

that I last saw her alive on Jan. 30, 1915 and that death occurred on the date stated above, at 5:25 a.m.  
The CAUSE OF DEATH\* was as follows:

Cardiac decompensation

Duration (Nigrodean) 18  
Contributory General Arterio sclerosis  
Secondary Myocarditis

Duration Unknown 18  
(Signed) George D. Dixson M.D.

Jan. 31, 1915 (Address) Sykesville, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 0 ds. 0 In the State Md. yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence. Prince George Co., Md.

19 PLACE OF BURIAL OR REMOVAL Washington DC

20 DATE OF BURIAL Feb 2, 1915

21 UNDERTAKER Gas R. Weer

22 ADDRESS By Reserve

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

(1) ✓

Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at *Home*, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Epidemic cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 5 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

454

County Carroll

120

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City Sykesville (No. Springfield State Maryland Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Eva Cohen

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
---------------------	------------------------------	---

6 DATE OF BIRTH

Unknown, 1891  
(Month) (Day) (Year)

7 AGE

23 (about)  
yrs. mos. ds. If LESS than  
1 day..... hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

None9 BIRTHPLACE  
(State or country)Unknown

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER  
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or country)Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Sykesville, Md.

15

Filed 1-7-1916 at White

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January 6, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 19, 1914, to Jan. 6, 1915,  
that I last saw her alive on Jan. 6, 1915,  
and that death occurred on the date stated above, at 1:20 P. M.  
The CAUSE OF DEATH\* was as follows:

Chronic Renal Hypertension  
Nephritis(Duration) Unknown yrs. mos. ds.Contributory Unknown  
Secondary(Duration) Unknown yrs. mos. 1/2 ds.(Signed) Edward S. Thompson, M. D.  
Jan. 6, 1915 (Address) Sykesville, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 18 ds. In the State Unknown yrs. mos. ds.Where was disease contracted, Place of death.  
If not at place of death?Former or usual residence Bay View Hospital20 PLACE OF BURIAL OR REMOVAL Hebron Cemetery DATE OF BURIAL Jan 8, 191520 UNDERTAKER Jack Lewis ADDRESS 1419 E. Balto.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

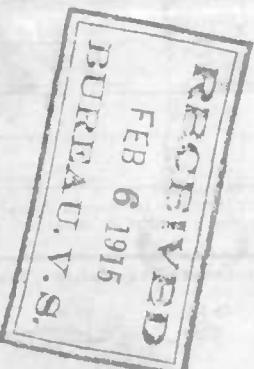
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, *e. g.*, *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Cancer*.

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Huanition," "Marsasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railroad train—accident; Recover wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

*If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.*



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

455

82

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 72

County Carroll St. Ward [If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Union Mills

**2 FULL NAME** Ester Isadore Dell

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** Female **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Married (Write the word)

**8 DATE OF BIRTH** Oct. 22, 1898 (Month) (Day) (Year)

**7 AGE** 22 yrs. 21 mos. 20 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

**9 OCCUPATION** Housewife  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

**10 NAME OF FATHER** Edward Everhart

**11 BIRTHPLACE OF FATHER** Carroll Co. Md. (State or country)

**12 MAIDEN NAME OF MOTHER** Clementine Legore

**13 BIRTHPLACE OF MOTHER** Carroll Co. Md. (State or country)

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) Allen Dell  
(Address) Union Mills Md.

Filed Feb. 5, 1915 J. W. Humbert

**15**

**16 DATE OF DEATH** January 11, 1915 (Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1914 to Jan. 11, 1915 that I last saw her alive on Dec. 11, 1914 and that death occurred on the date stated above, at 6:30 P.M. The CAUSE OF DEATH\* was as follows:

Embolism  
infarcting (Duration) yrs. mos. ds.

Contributory (Secondary) \_\_\_\_\_

(Duration) yrs. mos. ds.

Signed J. Lewis Wetzel, M. D.  
Dec. 11, 1915 (Address) Union Mills Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**  
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL** Silver Run Ind. DATE OF BURIAL Jan. 12, 1915

**20 UNDERTAKER** Edw. G. Graft ADDRESS Union Mills Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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oma. *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Oan-  
jer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dility" ("Con- genital," "Seizile," etc.), "Dropsy," "Exhaustion," "Harr failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—*accident*; *Revolver wound of head*—*homicide*; *Poisoned by carbolic acid*—*probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUERKEL, J. S.  
FEB 6 1915  
FEB 5 1915

## MARGIN RESERVED FOR BINDING

V. B. No. 1.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

456

(91)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 72

County Garrett St. Ward)

Village or City Unionville [It death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** Harry Edward Bell

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**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> <u>Male</u>	<b>4 COLOR OR RACE</b> <u>White</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word) <u>Single</u>
<b>8 DATE OF BIRTH</b> <u>April 1</u>		(Month) (Day) (Year) <u>(Month) April (Day) 1 (Year) 1913</u>
<b>7 AGE</b> <u>1 yrs. 9 mos. 10 ds.</u>		It LESS than 1 day, .... hrs. OR min. ?
<b>6 OCCUPATION</b> (a) Trade, profession, or particular kind of work... <u>000</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>000</u>		
<b>9 BIRTHPLACE</b> (State or country) <u>Tyrone Ind.</u>		
<b>10 NAME OF FATHER</b> <u>Allen Bell</u>		
<b>11 BIRTHPLACE OF FATHER</b> (State or country) <u>Garrett Co. Md.</u>		
<b>12 MAIDEN NAME OF MOTHER</b> <u>Ester H. Everhart</u>		
<b>13 BIRTHPLACE OF MOTHER</b> (State or country) <u>Garrett Co. Md.</u>		
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) <u>Allen Bell</u> (Address) <u>Unionville Ind.</u>		
<b>15</b> Filed <u>Feb 1, 1915</u> J. W. Humbert		

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH**  
January 10, 1915  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from Jan 1, 1915 to Jan 10, 1915, that I last saw him alive on Jan 10, 1915, and that death occurred on the date stated above, at 11:30 P.M., The CAUSE OF DEATH\* was as follows:

Bronchitis  
Pneumonia (Duration) 10 days  
Contributory (Secondary) Spotted  
Bronchitis (Duration) 3 months  
(Signed) L. Lewis W. Bell, M.D.  
Jan. 11, 1915 (Address) Unionville Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**  
At place of death yrs. mos. ds. To the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence...

**19 PLACE OF BURIAL OR REMOVAL** Silver Run Ind. **DATE OF BURIAL** Jan 13, 1915

**20 UNDERTAKER** John F. Grotz **ADDRESS** Unionville Ind.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

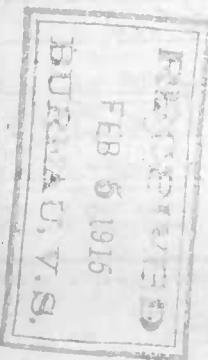
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*; *Carcin-*

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er" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), **29 ds.**; *Bronchopneumonia* (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Affection," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned dent*; *by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Carroll

457

28

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City Sykesville Md. (No. Springfield State Hop St. F Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rezia T Denny

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH <u>Aug 29, 1860</u>		
(Month) <u>Aug</u>	(Day) <u>29</u>	(Year) <u>1860</u>

7 AGE <u>54 yrs. 4 mos. 29 ds.</u>	If LESS than 1 day, hrs. OR min. ?
------------------------------------	------------------------------------

8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Clerk of Courts</u>
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) <u>Maryland</u>
--

10 NAME OF FATHER <u>William Denny</u>
--

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
---

12 MAIDEN NAME OF MOTHER <u>Mary H Hammond</u>
--

13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>
---

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____
---

(Address) _____
-----------------

15 Filed <u>1-29</u> , 1915 <u>W. W. Ritter</u> seal REGISTRAR
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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 28, 1915  
(Month) January (Day) 28 (Year) 1915

17 I HEREBY CERTIFY, That I attended deceased from

July 30, 1913, to Jan 28, 1915,  
that I last saw him alive on Jan 27, 1915,

and that death occurred on the date stated above, at 4:10 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

Unknown (Duration) Unknown yrs. Unknown mos. Unknown ds.

Contributory Secondary Organic Dementia  
Unknown (Duration) Unknown yrs. Unknown mos. Unknown ds.

(Signed) C. D. Hamilton, M. D.  
Jan 28, 1915 (Address) Sykesville Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 5 mos. 28 ds. In the State Md.

Where was disease contracted, If not at place of death? Unknown

Former or usual residence Baltimore Md.

19 PLACE OF BURIAL OR REMOVAL Baltimore Md. DATE OF BURIAL Jan 29, 1915

20 UNDERTAKER J. R. Weer ADDRESS Jefferson Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

(1)

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when relevant. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Aatrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *Spasis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

. FEB 6 1915

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County, Carroll

458

074

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 72

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City, Dwell 3 (No.)

## 2 FULL NAME

Philip Wesley Dietz

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word)
male.	white	married
6 DATE OF BIRTH		7 AGE
April 10		63 yrs. 9 mos. 15 ds.
		If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farm laborer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER Michael Dietz

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER Marie Elizabeth Yost

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amelia Dietz

(Address) Westminster Md

15 Filed Feb. 5, 1915  
F. J. W. Humbert  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 25, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from examined the body of the deceased 191 to that I last saw him alive on Jan. 25<sup>th</sup> 1915.

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Skull crushed from being caught in machinery belt  
Causing instantaneous death

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.  
(Signed) John F. Ziegler, M. D.  
1/26, 1915. (Address) Manchester Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  
at Bartholomew's, Jan. 28, 1915.

20 UNDERTAKER  
John F. Groft.  
ADDRESS  
Union Mills Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeeper* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the **disease causing death** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.* *Carcin-*

*oma*, *Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1915

BUREAU. V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 459  
County Carroll

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 75

Village or City Manchester (No.)

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary E. Everhart

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Dec 30th 1834, 1  
(Month) (Day) (Year)

7 AGE 80 yrs. 4 mos. 0 ds. IT LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Family duties  
(b) General nature of Industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) York Co., Pa.

10 NAME OF FATHER George Jerome

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Weaver

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. W. J. Everhart

(Address) Manchester, Md.

15 Filed 1/5, 1915 J. P. Ballozer

Local REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Jan. 4, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from did not attend deceased

that I last saw deceased die suddenly, was called after death and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Unknown disease probably pneumonia of the heart, caused by infirmity of old age

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) J. P. Ballozer (Duration) yrs. mos. ds.

(Address) Manchester, Md. M. D. Jan. 4th, 1915

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Manchester, Md. DATE OF BURIAL 1/6, 1915

20 UNDERTAKER J. P. Ballozer ADDRESS

J. P. Ballozer & Son, Manchester, Md.

(1)

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

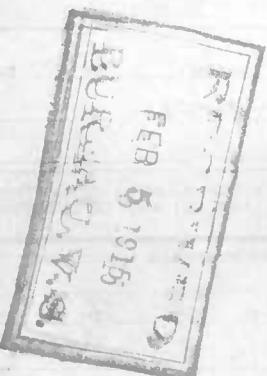
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

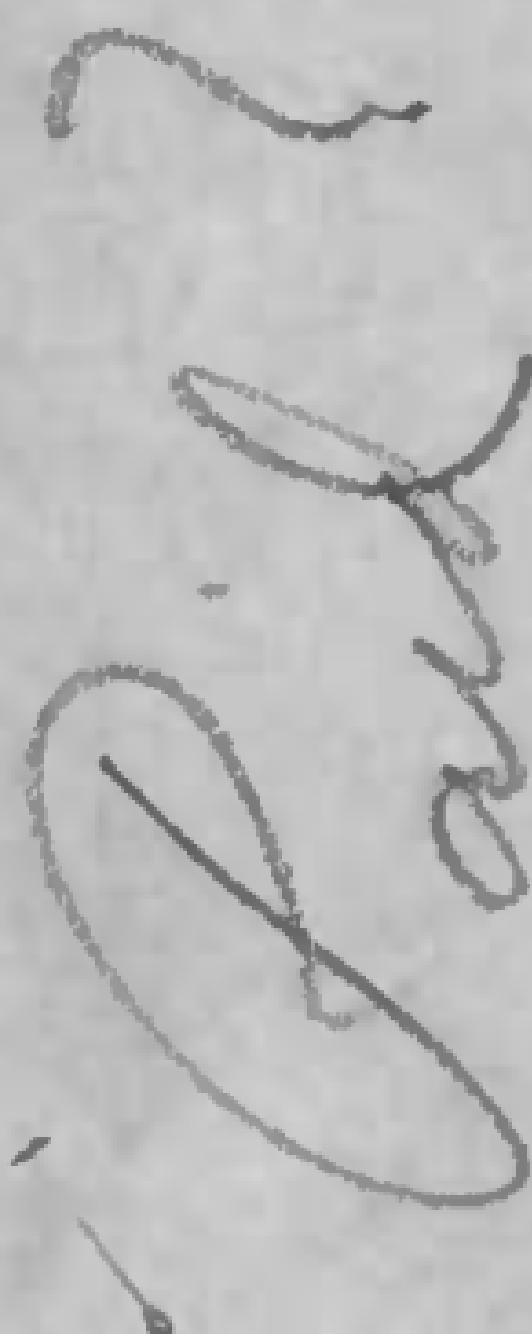
For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cotton*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Dehility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal pyrænitidis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Carroll

460

81

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City Sykesville (No. Springfield State Md. Ward 5)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Annie H. Ewart

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED

Single  
(Write the word)

## 6 DATE OF BIRTH

Unknown, 1  
(Month) (Day) (Year)

## 7 AGE

74 (about)  
yrs. mos. ds. If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housekeeper9 BIRTHPLACE  
(State or country)New York

## PARENTS

## 10 NAME OF FATHER

William Ewart11 BIRTHPLACE OF FATHER  
(State or country)New York

## 12 MAIDEN NAME OF MOTHER

Ely. Stevens13 BIRTHPLACE OF MOTHER  
(State or country)New York

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Record

(Address)

Sykesville, Md.

15

Filed 1-7

1915

W. W. White  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

January 7, 1915  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from April 1, 1914, to Jan 7, 1915.that I last saw her alive on Jan 6, 1915, and that death occurred on the date stated above, at 1:12 P. M.

The CAUSE OF DEATH\* was as follows:

General arteriosclerosis  
and hypertension(Duration) Unknown yrs. mos. ds.Contributory  
Secondary(Duration) Glo and Deyford yrs. mos. ds.(Signed) Van T., 1915 (Address) Sykesville, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 11 yrs. 9 mos. 6 ds. In the State Maryland ds.Where was disease contracted, Unknown. It not at place of death?Former or usual residence Caroline Co., Md.

## 19 PLACE OF BURIAL OR REMOVAL

Baltimore, Md. Jan 9, 1915

## 20 UNDERTAKER

Geo. R. Neel ADDRESS Sykesville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

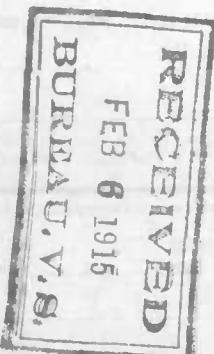
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

## Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasms, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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## 1 PLACE OF DEATH

461

County Garrett

(91)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 72

Village or City Union Mills

St. \_\_\_\_\_ Ward \_\_\_\_\_

• [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Ann Elizabeth Feser

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Widowed

## 6 DATE OF BIRTH

Dec 16 1826  
(Month) (Day) (Year)

## 7 AGE

88 yrs. 1 mos. 3 ds.If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.None(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)Garrett Co. Md.10 NAME OF  
FATHERPeter Feser11 BIRTHPLACE  
OF FATHER  
(State or country)Garrett Co. Md.12 MAIDEN NAME  
OF MOTHERAnna Feser13 BIRTHPLACE  
OF MOTHER  
(State or country)Garrett Co. Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Miss Susan Bish  
(Informant)Union Mills Md.  
(Address)

## 15

Filed Feb. 5, 1915 J. W. Humbert

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 19, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Jan. 1, 1915, to Jan. 19, 1915,  
that I last saw her alive on Jan 19, 1915,and that death occurred on the date stated above, at 9:50 P.M.,  
The CAUSE OF DEATH\* was as follows:BronchitisPneumonia (Duration) — yrs. — mos. — ds.Bronchitis (Duration) — yrs. — mos. — ds.(Signed) J. Lewis Wetzel, M.D.Jan 21, 1915 (Address) Union Mills Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Silver Run Jan 22, 1915

## 20 UNDERTAKER

Edw. F. Graft Union Mills Md.

DATE OF BURIAL

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*oma. *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cannular neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 5 1915

BUREAU, U. S.

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1 PLACE OF DEATH  
County Parsae

462

108

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 74

Village or City Sykesville (No. Springfield State Hospital, Ward 1)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lassie Ferguson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

## 6 DATE OF BIRTH

Unknown, 1, 1  
(Month) (Day) (Year)

## 7 AGE

17 yrs. 0 mos. 0 ds. If LESS than  
1 day, 0 hrs. OR 0 min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work  
Prostitute  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)

Massachusetts

## PARENTS

10 NAME OF  
FATHER

Unknown

11 BIRTHPLACE  
OF FATHER  
(State or country)

"

12 MAIDEN NAME  
OF MOTHER

"

13 BIRTHPLACE  
OF MOTHER  
(State or country)

"

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) Sykesville, Md.

## 15

Filed 1-8, 1915 W. W. Miller  
Local REGISTRAR

## DATE OF BURIAL

Sykesville Md Jan 8, 1915

## 20 UNDERTAKER

## ADDRESS

Gas R. Wier Sykesville Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Miscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasmodic tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Carroll 45

Village or City New Windsor (No. ....)

## 2 FULL NAME

Emanuel Frances Fisher

463

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 80St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	Married
6 DATE OF BIRTH <u>March 15<sup>th</sup></u>		7 AGE <u>67 yrs. 10 mos. 14 ds.</u>	IF LESS than 1 day, ____ hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farm</u>			
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>		10 NAME OF FATHER <u>Jacob Fisher</u>	
11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u>		12 MAIDEN NAME OF MOTHER <u>Catharine Geiselman</u>	
13 BIRTHPLACE OF MOTHER (State or country) <u>Pennsylvania</u>		14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Bernard Fisher</u> (Address) <u>New Windsor Md.</u>	

15 Filed Jan 30, 1915, by J. Edward West  
Local REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>January 29<sup>th</sup></u> , 1915 (Month) (Day) (Year)	17 I HEREBY CERTIFY, That I attended deceased from <u>Oct. 23<sup>rd</sup></u> , 1914, to <u>Jan. 29<sup>th</sup></u> , 1915, that I last saw him alive on <u>Jan. 29<sup>th</sup></u> , 1915, and that death occurred on the date stated above, at <u>940 A.M.</u> The CAUSE OF DEATH* was as follows:		
<u>Carcinoma of Bladder and Prostate Gland.</u>			
18 (Duration) <u>Unknown</u> yrs. mos. ds.			
Contributory (Secondary) <u>Nothing</u> yrs. mos. ds.			
(Duration) <u>Nothing</u> yrs. mos. ds.			
(Signed) <u>John G. Fisher</u> , M. D. <u>Jan. 29, 1915</u> (Address) <u>New Windsor</u>			
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. To the State ____ yrs. ____ mos. ds.			
Where was disease contracted, if not at place of death?			
Former or usual residence.			
20 PLACE OF BURIAL OR REMOVAL <u>Winton cemetery</u>		DATE OF BURIAL <u>Feb. 1<sup>st</sup></u> , 1915	
20 UNDERTAKER <u>H. Barnard &amp; Son</u>		ADDRESS <u>Westminster</u>	

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

### Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*

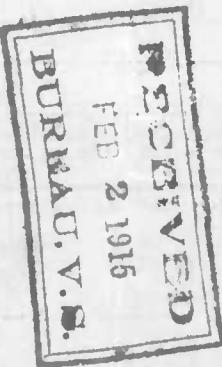
oma

Surcoma

etc.

of \_\_\_\_\_ (name origin: "Can-  
cer" is less definite; avoid use of "Tumor" for malig-  
nant neoplasms); *Measles*; *Whooping cough*; *Chronic  
valvular heart disease*; *Chronic interstitial nephritis*  
etc. The contributory (secondary or intercurrent)  
affection need not be stated unless important. Ex-  
ample: *Measles* (disease causing death), 29 d.;  
*Bronchopneumonia* (secondary), 10 d. Never report  
mere symptoms or terminal conditions, such as "As-  
thenia," "Anaemia" (merely symptomatic), "Atrophy,"  
"Collapse," "Coma," "Convulsions," "Debility" ("Co-  
genital," "Senile," etc.), "Dropsy," "Exhaustion,"  
"Heart failure," "Haemorrhage," "Inanition," "Maras-  
mus," "Old Age," "Shock," "Uraemia," "Weakness,"  
etc., when a definite disease can be ascertained as the  
cause. Always qualify all diseases resulting from  
childbirth or miscarriage, as "Puerperal septic-  
mia," "Puerperal peritonitis," etc. State cause for  
which surgical operation was undertaken. For vi-  
olent deaths state means of INJURY and qualify as  
ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*  
such, if impossible to determine definitely. Examples:  
*Accidental drowning*; *Struck by railway train—acci-  
dental*; *Revolver wound of head—homicide*; *Poisoned  
by carbolic acid—probably suicide*. The nature of the  
injury, as fracture of skull, and consequences (e. g.,  
"sepsis, tetanus") may be stated under the head of  
"Contributory." (Recommendations on statement of  
cause of death approved by Committee on Nomencla-  
ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-  
tions answered in detail, it will prevent further correspond-  
ence. All the data is essential and must be obtained before  
the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

464

County Carroll,

137

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 77

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Hampstead, (No.)

2 FULL NAME Mary Ray Fritz,

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female.	White.	Married.

6 DATE OF BIRTH	6, 28, 1891 (Month) (Day) (Year)
-----------------	-------------------------------------

7 AGE	28, yrs. 6, mos. 12 ds.	If LESS than 1 day.....hrs. OR.....min. ?
-------	-------------------------	---

8 OCCUPATION	Housewife.
(a) Trade, profession, or particular kind of work.	
(b) General nature of industry, business, or establishment in which employed (or employer)	

9 BIRTHPLACE (State or country)	Hampstead, Md.
------------------------------------	----------------

10 NAME OF FATHER	William D. Brown,
-------------------	-------------------

11 BIRTHPLACE OF FATHER (State or country)	Hampstead, Md.
---	----------------

12 MAIDEN NAME OF MOTHER	Anna Maria Blizzard,
--------------------------	----------------------

13 BIRTHPLACE OF MOTHER (State or country)	Hampstead, Md.
---	----------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)	David W. Brown
---	----------------

15 (Address)	Hampstead, Md.
-----------------	----------------

16 Filed Jan 6, 1915 - Am. A. Abbott	
---	--

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH	1, 5, 1915 (Month) (Day) (Year)
------------------	------------------------------------

17	I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1914 to Jan. 5, 1915,
----	--

that I last saw her alive on Jan. 5, 1915,
--

and that death occurred on the date stated above, at 4 A.M.
---

The CAUSE OF DEATH* was as follows: Childbirth.
--

(Duration) yrs. mos. ds.
--------------------------

Contributory Puerperal Septicæmia. Secondary
---

(Duration) yrs. mos. ds.
--------------------------

(Signed) Edgar M. Bush, M. D.
-------------------------------

1/5/15, 1915 (Address) Hampstead, Md.
---------------------------------------

(Duration) yrs. mos. ds.
--------------------------

(Signed) Edgar M. Bush, M. D.
-------------------------------

1/5/15, 1915 (Address) Hampstead, Md.
---------------------------------------

(Duration) yrs. mos. ds.
--------------------------

(Signed) Edgar M. Bush, M. D.
-------------------------------

1/5/15, 1915 (Address) Hampstead, Md.
---------------------------------------

(Duration) yrs. mos. ds.
--------------------------

At place of death yrs. mos. ds. In the State yrs. mos. ds.
--

Where was disease contracted, if not at place of death?
---

Former or usual residence.
----------------------------

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
---

At place of death yrs. mos. ds. In the State yrs. mos. ds.
--

Where was disease contracted, if not at place of death?
---

Former or usual residence.
----------------------------

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
-------------------------------	----------------

Hampstead Md	1-6, 1915
--------------	-----------

20 UNDERTAKER	ADDRESS
---------------	---------

J. V. Tipton & Son	Hampstead Md
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If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

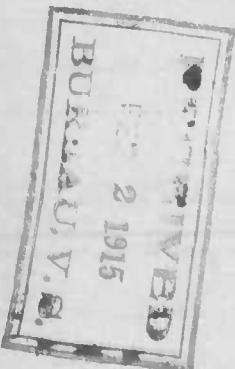
(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic vascular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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## 1 PLACE OF DEATH

County Baltimore

465

Village or City Mr. Linwood (No. ....)

81

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 81

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jesse Gibson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
-------------------	--------------------------------	---

6 DATE OF BIRTH 10 - 8, 1883  
(Month) (Day) (Year)

7 AGE 31 yrs. 2 mos. 24 ds. If LESS than  
1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Auto Chauffeur  
(b) General nature of industry, business, or establishment in which employed (or employer) 510

9 BIRTHPLACE  
(State or country) Carroll Co. Md

10 NAME OF FATHER Aliph Gibson

11 BIRTHPLACE OF FATHER  
(State or country) Franklin Co. Pa

12 MAIDEN NAME OF MOTHER Emma Lewis

13 BIRTHPLACE OF MOTHER  
(State or country) Carroll Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Aliph Gibson

(Address) Union Bridge Md

15 Jan 5<sup>th</sup>, 1915 Leslie Raft  
Filed Deputy Reg. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 5<sup>th</sup>, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1915, to Jan 5<sup>th</sup>, 1915,  
that I last saw him alive on Jan 2, 1915.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Aneurism of Aorta  
Causing cerebral em-  
bolism

(Duration) 3 yrs. mos. ds.

Contributory  
(Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) Leslie Raft, M. D.

Jan 5, 1915 (Address) Union Bridge Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Mount Joy Jan 5, 1915

20 UNDERTAKER Frank J. Shriver

ADDRESS Union Bridge Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Gastric" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic vulnerable heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles*, (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 4 1915

BURKAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Carroll 120

Village or City Sykesville (No. Springfield State Hosp St. E Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 74

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Josiah P V Gordy

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
-------------------	------------------------------	--

6 DATE OF BIRTH — — — —, 1848  
(Month) (Day) (Year)

7 AGE 67 yrs. — mos. — ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work. Farmer  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) —

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF  
FATHER Unknown

11 BIRTHPLACE  
OF FATHER  
(State or country) Maryland

12 MAIDEN NAME  
OF MOTHER Unknown

13 BIRTHPLACE  
OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hastings Springfield Hosp  
(Address) Sykesville Md

15 Filed 1-29, 1915 W.W. Miller  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 28  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
April 14, 1915, to Jan. 28, 1915,

that I last saw him alive on Jan. 27, 1915,

and that death occurred on the date stated above, at 145 P.m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis, nephritis

Unknown (Duration) — yrs. — mos. — ds.

Contributory Arterio Sclerosis  
Secondary Unknown (Duration) — yrs. — mos. — ds.

(Signed) C. D. Hamilton, M. D.

Jan. 28, 1915 (Address) Sykesville

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place — yrs. — mos. — ds. In the State Md mos. — ds.

Where was disease contracted, Unknown  
If not at place of death?

Former or usual residence Wicomico Co.

19 PLACE OF BURIAL OR REMOVAL Frederickburg Md Jan. 29, 1915

UNDERTAKER Gas R. Lee ADDRESS Sykesville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal mortification," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

H. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Carroll

467

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 71Village or City Not-Union (No. ....)2 FULL NAME Samuel H. Graham

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
-------------------	------------------------------	--

6 DATE OF BIRTH

Nov 19, 1833  
(Month) (Day) (Year)

7 AGE

81 yrs. 2 mos. 11 ds.  
If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work Retired Farmer  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE

(State or country)

Baltimore Co Pa

10 NAME OF FATHER

William Graham11 BIRTHPLACE OF FATHER  
(State or country)Scotland

12 MAIDEN NAME OF MOTHER

Susan Rowe13 BIRTHPLACE OF MOTHER  
(State or country)Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah J. Wilson

(Address)

Middleburg Ind

15

Filed

Jan 30th, 1915

REGISTRAR

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

St. \_\_\_\_\_ Ward \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 30th, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Nov. 13, 1914, to Jan 30, 1915,

that I last saw him alive on Jan 29, 1915,  
and that death occurred on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(Duration) yrs. 3 mos. 17 ds.  
Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Duration) yrs. 1 mos. 0 ds.  
Luther Stump, M. D.

(Signed) Jan 30 1915 (Address) Uniontown Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
If not at place of death?Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Uniontown MdDATE OF BURIAL  
Feb 1, 1916

20 UNDERTAKER

C. O. Fiss & Son Janeytown Md

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

(1)

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

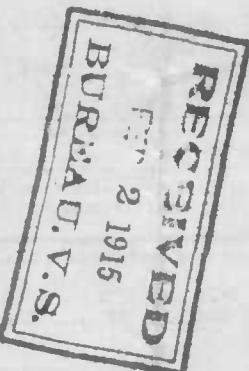
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marmasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Carroll 463 (28)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City Sykesville (No. Springfield State Hosp St. F Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Leon Gray

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male White

## 4 COLOR OR RACE

Single  
5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

## 6 DATE OF BIRTH

— — —, 1894  
(Month) (Day) (Year)

## 7 AGE

20 yrs. mos. ds. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

## 9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER

(State or country)

Virginia

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER

(State or country)

Virginia

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) History Springfield State Hosp

(Address) Sykesville Md

## 15

Filed 1-4, 1915 W. W. Ritter

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

January 3, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 10, 1914, to Jan 3, 1915

that I last saw him alive on Jan 2, 1915

and that death occurred on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. 4 mos. — ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) C. D. Hasseltown, M. D.

Jan 3, 1915 (Address) Sykesville Md

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place 3 yrs. — mos. 29 ds. In the State Yes mos. — ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Baltimore Md

## 19 PLACE OF BURIAL OR REMOVAL

Baltimore City Jan 5, 1915

## 20 UNDERTAKER

Gas R. Weir ADDRESS Sykesville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Gruop"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPEAL septicæmia," "PUERPEAL pueritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Carroll

469

(151)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 83Village or City Mar Day (No.)St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

William Jesse Grimes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)
-------------------	------------------------------	---

## 6 DATE OF BIRTH

Jan 20, 1915  
(Month) (Day) (Year)

## 7 AGE

yrs. 0 mos. 0 ds. 0 If LESS than  
1 day, 5 hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
None(b) General nature of industry, business, or establishment in which employed (or employer)  
None9 BIRTHPLACE  
(State or country)Carroll Co

## 10 NAME OF FATHER

Jesse E Grimes11 BIRTHPLACE OF FATHER  
(State or country)Carroll Co

## 12 MAIDEN NAME OF MOTHER

Jessie Flora Gornell13 BIRTHPLACE OF MOTHER  
(State or country)Carroll Co

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse E Grimes(Address) Mar Day Ind

## 15

Filed Jan 29, 1915 William Glennan  
Deputy

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 28, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Jan 28, 1915, to Jan 28, 1915  
that I last saw him alive on Jan 28, 1915  
and that death occurred on the date stated above, at 3 P.M.,  
The CAUSE OF DEATH\* was as follows:Immature birth  
exhaustion of months  
(Duration) 5 hours  
yrs. 0 mos. 0 ds.Contributory  
(Secondary) Immature  
(Duration) 0 yrs. 0 mos. 0 ds.(Signed) C D Clark, M. D.  
Jan 29, 1915 (Address) Woodbine

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place Mar Day yrs. 0 mos. 0 ds. In the State yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Morgan Cemetery Jan. 29, 1915

## 20 UNDERTAKER

Jameson Pickethorn Woodbine Ind

DATE OF BURIAL

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

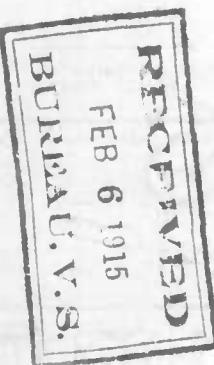
Association.]

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*oma*, *Sarcoma*, etc., of ..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 4s.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Postpartal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH		470
County <u>Carroll</u>		79
Village or City <u>Manchester</u> (No.)		75
2 FULL NAME <u>John Thomas Grosse</u>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
6 DATE OF BIRTH <u>Sept 24</u> (Month) <u>1836</u> (Year)		
7 AGE <u>78</u> yrs. <u>3</u> mos. <u>21</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?		
8 OCCUPATION <u>Plasterer</u> (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE <u>Maryland</u> (State or country)		
10 NAME OF FATHER <u>John Grosse</u>		
11 BIRTHPLACE OF FATHER <u>Maryland</u> (State or country)		
12 MAIDEN NAME OF MOTHER <u>Mary Frank Foster</u>		
13 BIRTHPLACE OF MOTHER <u>Maryland</u> (State or country)		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John T. Grosse</u> (Address) <u>Manchester Md.</u>		
15 Filed <u>1/17</u> , 1915 J P Baltozer Local REGISTRAR		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 75

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH <u>Jan 16</u> (Month) <u>1915</u> (Day) <u>1915</u> (Year)		
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan</u> , 1914, to <u>Jan 15</u> , 1915, that I last saw him alive on <u>Jan 13</u> , 1915, and that death occurred on the date stated above, at <u>2</u> P. m.		
The CAUSE OF DEATH* was as follows: <u>Hypertrophy of heart with mural</u> <u>Emphysema</u>		
(Duration) yrs. mos. ds.		
Contributory Secondary <u>Senile Gangrene</u>		
(Duration) yrs. mos. ds.		
(Signed) <u>J H Sherman</u> , M. D. <u>Jan 16</u> , 1915 (Address) <u>Manchester Md.</u>		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds		
Where was disease contracted, if not at place of death?		
Former or usual residence.		
19 PLACE OF BURIAL OR REMOVAL <u>Manchester Md</u>		DATE OF BURIAL <u>Jan 18, 1915</u>
20 UNDERTAKER <u>Local</u>		ADDRESS <u>Jacob Wink &amp; Son Manchester Md</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

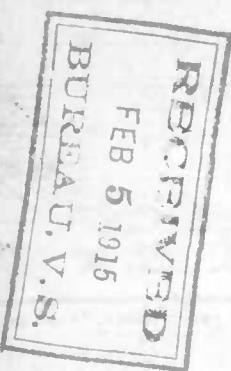
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner, (b) Cotton mill; (a) Sacksman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At home, and children, not gainfully employed, as At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic catarrhal heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Carroll

471

67

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City Sykesville (No. Springfield St. Ward) 8

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Chas. E. Hahn

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
-------------------	------------------------------	---

6 DATE OF BIRTH

unknown, 1  
(Month) (Day) (Year)

7 AGE

34 yrs. 0 mos. 0 ds.

If LESS than  
1 day, 0 hrs.  
OR 0 min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.  
unknown

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

unknown

10 NAME OF FATHER

II

11 BIRTHPLACE OF FATHER

(State or country)

II

12 MAIDEN NAME OF MOTHER

II

13 BIRTHPLACE OF MOTHER

(State or country)

II

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital records(Address) Sykesville Md

15

Filed 1-19, 1915 W.M. Ritter  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 18, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 3rd, 1913, to Jan 18, 1915

that I last saw him alive on Jan 18, 1915and that death occurred on the date stated above, at 2-35 P.M.

The CAUSE OF DEATH\* was as follows:

General Paralysis of the insane

(Duration) 3 yrs. — mos. — ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) W.M. Ritter, M. D.

1-18-1915 (Address) Sykesville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place II yrs. 5 mos. — ds. In the unknown State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence Baldo City

19 PLACE OF BURIAL OR REMOVAL Baltimore City DATE OF BURIAL Jan 19 191520 UNDERTAKER Chas R. WeirADDRESS Baltimore Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report were symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 6 1915
BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Carroll

472

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 77

Village or City Hampstead (No. ....)

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Bessie A Tyson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

## 6 DATE OF BIRTH

Jan 16, 1885  
(Month) (Day) (Year)

## 7 AGE

30 yrs. .... mos. 5- ds. If LESS than  
1 day, .... hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work Nurse  
(b) General nature of industry, business, or establishment in which employed (or employer) 9 Hospital

## 9 BIRTHPLACE

(State or country) Maryland

## 10 NAME OF FATHER

David A Tyson

## 11 BIRTHPLACE OF FATHER

(State or country) Pennsylvania

## 12 MAIDEN NAME OF MOTHER

Clara Peny

## 13 BIRTHPLACE OF MOTHER

(State or country) Pennsylvania

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward A Tipton(Address) Hampstead Md

## 15

Filed Jan 22, 1915 Ms A Abbott

REGISTRAR

117

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 21, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, THAT I attended deceased from Jan 18, 1915, to Jan 21, 1915,  
that I last saw her alive on Jan 21, 1915,  
and that death occurred on the date stated above, at 2301.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) C. A. P. Tyson, M. D. Jan 21, 1915 (Address) Hampstead

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
If not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hampstead Md Jan 23, 1915

## 20 UNDERTAKER

ADDRESS

C. W. Tipton & Son Hampstead Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonacum, etc., Cancer-*

*oma, Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Drowsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Carroll 473 (92) 1132

Village or City Pleasant Valley (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 76

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Carroll Lester

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH July 24, 1899  
(Month) (Day) (Year)

7 AGE 15 yrs. 5 mos. 10 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION none  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer) Going to School

9 BIRTHPLACE Carroll Co Md  
(State or country)

10 NAME OF FATHER Aaron Lester

11 BIRTHPLACE OF FATHER Carroll Co Md  
(State or country)

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER Carroll Co Md  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Aaron Lester

(Address) Westminster

15 Filed Jan 7th 1915 E. W. Shirren

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 4, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1914, to Jan 4, 1915,

that I last saw him alive on Jan 4, 1915, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH\* was as follows:

Salesman pneumonia

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John J. Stover, M. D.  
Jan 6, 1915 (Address) Westminster Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL Jan 6, 1915

20 UNDERTAKER James M. Stover ADDRESS Westminster

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcinoma*. *Sarcoma*, etc., or (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BURKHAU, V. G.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County Carroll 474  
 Village or City Gamber (No. 56)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 3

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Thomas Ray Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

June 26, 1875  
 (Month) (Day) (Year)

7 AGE

39 yrs. 6 mos. 26 ds. If LESS than  
 1 day, hrs.  
 OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
 particular kind of work.(b) General nature of industry,  
 business, or establishment in  
 which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Jan 26 1915  
mg Lester

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 21, 1915  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 18, 1915, to Jan 21, 1915  
 that I last saw him alive on Jan 20, 1915

and that death occurred on the date stated above, at 2 a.m.  
 The CAUSE OF DEATH\* was as follows:

Acute cerebral thrombosis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Henry M. Lighthill, M.D.  
Jan 21, 1915 (Address) Westminster Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the  
 of death yrs. mos. ds. State yrs. mos. ds

Where was disease contracted,  
 It not at place of death?

Former or  
 usual residence

19 PLACE OF BURIAL OR REMOVAL

Gamber

DATE OF BURIAL

Jan 23, 1915

20 UNDERTAKER

Frank G. Shaffer

ADDRESS

Westminster

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma, Sarcoma, etc.* of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 8 1915
BUREAU V.S.

# BURIAL PERMIT OF LOCAL BOARD OF HEALTH.

No. ....

In the town of Finksburg County of Carroll  
(City or Town)

State of Maryland on the 21st day of January 1905

Permission is hereby given to Frank C Shaffer, Undertaker, to remove for burial  
at Mt. Pleasant Cemetery in the County of Carroll,

State of Md. the body of Thomas Ray Miller,  
who died at Baumer, County of Carroll, on the 21st day of

Jan 1905 Aged 39 years 6 months 26 days.

The cause of death was Delerium Tremens Signed Lehas. R. Foutz

Secretary  
Local Board of Health.

Forward this to -  
Marine & Seaside  
Local Ref.  
Moorings' Diet

by order

of Helen Bryant M.D.  
County Collector  
Notary Public  
Carroll County  
Maryland

Entered in my  
Clerk's Office Jan 23 - 1915

P. S. Barnes  
Secretary

RECEIVED

FEB 8 1915

BUREAU, U. S.



# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

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1 PLACE OF DEATH  
County Carroll

476

64

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 77Village or City Hampstead (No. ....)

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Richard H. Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) widower

## 6 DATE OF BIRTH

Lee 19 1834  
(Month) (Day) (Year)

## 7 AGE

80 yrs. 21 mos. 0 ds. If LESS than  
1 day, .... hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work Farmer  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Own farm

## 9 BIRTHPLACE

(State or country) Maryland

## 10 NAME OF FATHER

Jacob Miller

## 11 BIRTHPLACE OF FATHER

(State or country) Maryland

## 12 MAIDEN NAME OF MOTHER

Elizabeth Richards

## 13 BIRTHPLACE OF MOTHER

(State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant) Edgar E. Tipton(Address) Hampstead Md.15 Filed Jan 10, 1915 Sam G. Abbott

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 10, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Lee 26, 1914, to Jan 9, 1915,

that I last saw Miller alive on Jan 9, 1915,

and that death occurred on the date stated above, at 12130 Am.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) R. G. Wells (Address) Hampstead M. D.

(Signed) Jan 10, 1915 (Address) Hampstead

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Hampstead Md. DATE OF BURIAL 1-12, 1915

## 20 UNDERTAKER

C. V. Tipton & Son ADDRESS Hampstead Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

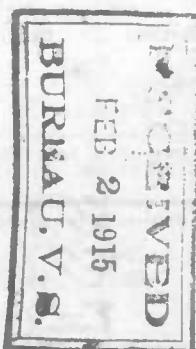
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal puerperitis," etc. State cause for which surgical operation was undertaken. For violent death state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railroad train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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1 PLACE OF DEATH  
County Carroll

477

79

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City Sykesville(No. 1)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Augustus Morelock

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
-------------------	------------------------------	--

6 DATE OF BIRTH September  
(Month) (Day) (Year)

7 AGE <u>69</u> yrs.	If LESS than 1 day, .... hrs. OR ..... min. ?
-------------------------	---

8 OCCUPATION Retired  
(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE Carroll Co  
(State or country)

10 NAME OF FATHER Wm. Morelock

11 BIRTHPLACE OF FATHER "  
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER "  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital record  
(Address) Sykesville Md

15 Filed 4/16 1915 W. W. Whittier  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 16, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1914, to Jan 16, 1915,

that I last saw him alive on Jan 15, 1915,

and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH\* was as follows:

Auto Dilatation of heart  
(Duration) 1 hr. yrs. 0 mos. 0 ds.

Contributory Arterio Sclerosis & Hypertension  
Secondary

(Duration) 10 years yrs. 0 mos. 0 ds.

(Signed) H. S. Tuckman, M. D.

1-16, 1915 (Address) Sykesville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 0 mos. 0 ds. In the State Carroll Co yrs. 0 mos. 0 ds.

Where was disease contracted, Carroll Co Md  
If not at place of death?

Former or usual residence Carroll Co Md

19 PLACE OF BURIAL OR REMOVAL Beechamere Home DATE OF BURIAL Jan 18, 1915

20 UNTAKER James M. Stoner ADDRESS Westminster

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dairy laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congeital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recovert wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *Scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 8 1915



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Carroll

Village or City Ridgeville (No. ....)

2 FULL NAME Nellie Josephine Mullinix

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) Married

## 6 DATE OF BIRTH

May 26<sup>th</sup>, 1891  
(Month) (Day) (Year)

7 AGE 23 yrs 7 mos 29 ds. If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

House wife

9 BIRTHPLACE  
(State or country)

Carroll Co. Md.

10 NAME OF  
FATHER

Wm. Edward Browning

11 BIRTHPLACE  
OF FATHER  
(State or country)

Montgomery Co. Md.

12 MAIDEN NAME  
OF MOTHER

Eliza M. Rightfoot

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Roxbury Co. Vt.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. M. Browning

(Address)

Mt. Airy, Md.

## 15

Filed Jan. 7, 1915 — Robert L. Cimberly

REGISTRAR

478

137

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 82

[If death occurred in a hospital or institution,  
give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan. 24<sup>th</sup>, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Jan. 19<sup>th</sup>, 1915, to Jan. 24<sup>th</sup>, 1915,  
that I last saw her alive on Sunday, Jan 24<sup>th</sup>, 1915,  
and that death occurred on the date stated above, at 2:40 P.M.  
The CAUSE OF DEATH\* was as follows:

Puerperal Peritonitis

(Duration) — yrs. — mos. — ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) J. Albert Nice, M. D.  
Jan. 25<sup>th</sup>, 1915 (Address) Mt. Airy, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL  
Grave Ground not any DATE OF BURIAL  
Jan. 26, 1915

## 20 UNDERTAKER

Basil W. Bonnar ADDRESS  
Mt. Airy, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

1

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when pertinent. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonium*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by earabolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 16 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Carroll

479

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 24

Village or City Sykesville (No. Springfield State Hosp St. C Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Daniel O'Brien

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED MARRIED  
(Write the word)

6 DATE OF BIRTH Unknown, 1850  
(Month) (Day) (Year)

7 AGE 65 yrs. — mos. — ds. If LESS than  
1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work. Bar Keeper  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) 80

9 BIRTHPLACE  
(State or country) Ireland

10 NAME OF  
FATHER John O'Brien

11 BIRTHPLACE  
OF FATHER  
(State or country) Ireland

12 MAIDEN NAME  
OF MOTHER Unknown

13 BIRTHPLACE  
OF MOTHER  
(State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) History Springfield State Hosp

(Address) Sykesville Md

15 Filed 1-25-1915 W.W. Atter  
Local REGISTRAR

91

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 24, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
July 15, 1914, to Jan 24, 1915,

that I last saw him alive on Jan 24, 1915,

and that death occurred on the date stated above, at 4:17 P.M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(Duration) — yrs. — mos. 3 ds.

Contributory Mitral Regurgitation  
Secondary Unknown

(Duration) — yrs. — mos. ds.

(Signed) C. D. Hamilton, M. D.  
Jan 24, 1915 (Address) Sykesville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place 18 yrs. 2 mos. 17 ds. In the State Unknown yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Baltimore Md

19 PLACE OF BURIAL OR REMOVAL Baldo City DATE OF BURIAL Jan 25, 1915

20 UNDERTAKER Joe B. Weer ADDRESS Sykesville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Taborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 6 1915

BUREAU, W.E.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Carroll

480

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 75Village or City 6th & Dixie near ManchesterSt. Ward)

## 2 FULL NAME

Catherine K Reed

[If death occurred in a Hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)married

## 6 DATE OF BIRTH

Sep. 26<sup>th</sup>  
(Month) (Day) (Year)

## 7 AGE

59 yrs. 3 mos. 28 ds.If LESS than  
1 day.....hrs.  
OR.....min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

## 9 BIRTHPLACE

(State or country)

Baltimore Co., Md.

## PARENTS

## 10 NAME OF FATHER

John P Smith

## 11 BIRTHPLACE OF FATHER

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

unknown

## 13 BIRTHPLACE OF MOTHER

(State or country)

unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Reed

(Address)

Hanover Ind.

## 15

Filled

1/26/1915J. P. BaltozerLocalREGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Aug. 24<sup>th</sup>

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug. 18<sup>th</sup> 1915 to Aug. 23<sup>rd</sup> 1915that I last saw her alive on Aug. 23<sup>rd</sup> 1915and that death occurred on the date stated above, at Aug. 24<sup>th</sup> 1915 6 A. m.

The CAUSE OF DEATH\* was as follows:

Acute Diabetes MellitusThe patient has been afflicted with  
Chronic diabetes for about eight years,  
and finally Acute (Duration) yrs. 6 mos. 6 ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. P. Weaver, M. D.  
Aug. 25<sup>th</sup> 1915 (Address) Manchester, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Manchester Cemetery Jan. 27<sup>th</sup> 1915

## 20 UNDERTAKER

Jacob Wink & Sons Manchester

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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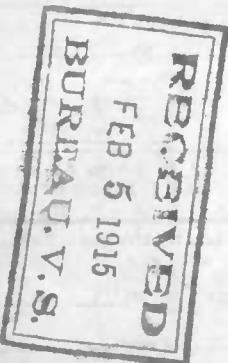
For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Mauager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cercospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 481  
 County Carroll (120) 1133  
 Village or City Westminster (No.)  
 Person (Name) Martha Ellen Richardson

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Apr 99, 1855 (Month) (Day) (Year)

7 AGE 79 yrs. 6 mos. 8 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work... house  
 (b) General nature of industry, business, or establishment in which employed (or employer) ...

9 BIRTHPLACE (State or country) Carroll Co Md.

10 NAME OF FATHER Mr. Engleman

11 BIRTHPLACE OF FATHER (State or country) Carroll

12 MAIDEN NAME OF MOTHER Alice Younger

13 BIRTHPLACE OF MOTHER (State or country) Carroll Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Edward Richardson  
 (Address) Melford Ward

15 Filed Jan 10, 1915 E. W. Turner

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

16 DATE OF DEATH Jan. 7<sup>th</sup>, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ~~of securer~~, 1914 to Jan 7<sup>th</sup>, 1915, that I last saw her alive on Jan. 6<sup>th</sup>, 1915, and that death occurred on the date stated above, at 7 A. m., The CAUSE OF DEATH\* was as follows:

*Macrococcosis - Cardiac failure*

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death yrs. mos. ds. In the State yrs. mos. ds.  
 Where was disease contracted, if not at place of death?  
 Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL *Westminster Cemetery* DATE OF BURIAL Jan. 10, 1915  
 20 UNDERTAKER *H. Bankard & Son Westminster* ADDRESS

REVISED UNITED STATES STANDARD

**CERTIFICATE OF DEATH**

[Approved by U. S. Census and American Public Health

### Association.]

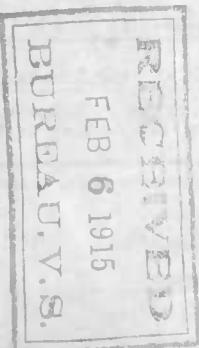
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*,

**Civil engineer, Compositor, Architect, Locomotive engineer,**  
**Physician, Stationary foreman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as **Day laborer**, **Farm laborer**, **Laborer**—Cook **mine**, etc. Women at home, who are engaged in the duties of the household only (not paid **Housekeepers** who receive a definite salary), may be entered as **Housewife**, **Housework**, or **At Home**, and children, notwithstanding they are employed, as **At school** or **At home**. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as **Servant**, **Cook**, **Housmaid**, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: **Farmer (retired 6 yrs.)**. For persons who have no occupation whatever, write **None**.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*

o.m.; *Surcoma*, etc., of ..... (name origin: "Cap-  
er" is less definite; avoid use of "Tumor" for malignant  
neoplasms); *Measles*; *Whooping cough*; *Chronic  
valvular heart disease*; *Chronic interstitial nephritis*,  
etc. The contributory (secondary or intercurrent)  
affection need not be stated unless important. Example:  
*Measles* (disease causing death), 29 da.;  
*Bronchopneumonia* (secondary), 10 d. Never report  
mere symptoms or terminal conditions, such as "As-  
thenia," "Anaemia" (merely symptomatic), "Atrophy,"  
"Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion,"  
"Heart failure," "Haemorrhage," "Inanition," "Mara-  
asmus," "Old Age," "Shock," "Uraemia," "Weakness,"  
etc., when a definite disease can be ascertained as the  
cause. Always qualify all diseases resulting from  
childbirth or miscarriage, as "Puerperal septicemia,"  
"Puerperal peritonitis," etc. State cause for  
which surgical operation was undertaken. For vio-  
lent deaths state means of injury and qualify as  
ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*  
such, if impossible to determine definitely. Examples:  
*Accidental drowning*; *Struck by railway train*—acci-  
dental; *Revolver wound of head*—homicide; *Poisoned*  
by *carbolic acid*—probably suicide. The nature of the  
injury, as fracture of skull, and consequences (e.g.,  
*scpsis, tetanus*) may be stated under the head of  
"Contributory." (Recommendations on statement of  
cause of death approved by Committee on Nomencla-  
ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-  
tions answered in detail, it will prevent further correspond-  
ence. All the data is essential and must be obtained before  
the certificate is permanently filed.



BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Carroll

452

STATE OF MARYLAND  
CERTIFICATE OF DEATH 79

Registration Dist. No. 81

Village or City Kensett (No. )

St. — Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

October 15, 1857  
(Month) (Day) (Year)

7 AGE

57 yrs 3 mos 8 ds.

It LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work. Post Commissioner  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed July 2, 1915Leslie F. Webb  
Deputy Registrar

15

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 22, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov. 1, 1914, to Jan. 22, 1915that I last saw him alive on Jan. 22, 1915and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH\* was as follows:

Gastricoma of Liver

(Duration) — yrs. 8 mos. — ds.

Contributory  
Secondary

(Duration) — yrs. mos. ds.

(Signed) Roland R. Dyer, M. D.  
Jan. 22, 1915 (Address) Detour, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Mauritanian Farm

20 UNDERTAKER

Frank J. ShriverDATE OF BURIAL  
24 Jan, 1915ADDRESS  
Union BridgeMD

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

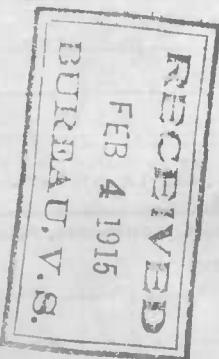
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensitis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 483  
County Carroll

(79)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City Sykesville (No. Springfield Hospital St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rebecca Schuemaker

PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>		
6 DATE OF BIRTH <u>Unknown</u>		(Month)	(Day)	(Year) <u>1838</u>
7 AGE <u>77</u>	YRS.	MOS.	DS.	IF LESS than 1 day,.....hrs. OR min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>				
9 BIRTHPLACE (State or country) <u>Pa.</u>				
10 NAME OF FATHER <u>Unknown</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>				
12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>				

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Springfield Hosp. Records

(Address) Sykesville Md

15

Filed 4-2 1915 W.W. Miller

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 1<sup>st</sup>, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13<sup>th</sup>, 1915, to Jan. 1<sup>st</sup>, 1915.

that I last saw her alive on Jan. 1<sup>st</sup>, 1915.

and that death occurred on the date stated above, at 6.50 P. M.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis + Myocarditis

unknown (Duration) yrs. mos. ds.

Contributory Secondary Hypertrophic Pulmonaria

(Duration) yrs. mos. 3 ds.

(Signed) John Norfolk Morris, M. D.  
Jan. 1<sup>st</sup>, 1915. (Address) S.S. Hosp. Sykesville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 11 mos. 19 ds. In the Unknown  
State Carroll Co. Md

Where was disease contracted, if not at place of death? Carroll Co. Md

Former or usual residence. Taneytown, Carroll Co. Md.

19 PLACE OF BURIAL OR REMOVAL Taneytown Md DATE OF BURIAL Jan. 2<sup>nd</sup>, 1915

20 UNDERTAKER Gas T. Weer

ADDRESS Sykesville Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations, a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc. of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Tuerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spiss, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BURNAU, W. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Carroll

484

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 75St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Melrose (No. ....)2 FULL NAME Sarah Catharine Sellers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

## 6 DATE OF BIRTH

May 22, 1847  
(Month) (Day) (Year)

## 7 AGE

67 yrs. 7 mos. 19 ds. If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country) Maryland

## PARENTS

## 10 NAME OF FATHER

Daniel Bigler

## 11 BIRTHPLACE OF FATHER

(State or country) Maryland

## 12 MAIDEN NAME OF MOTHER

Mary Ellen Mathias

## 13 BIRTHPLACE OF MOTHER

(State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah A. Sellers(Address) Manchester School

15

Filed 1/13, 1915 J. P. Ballozer

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

January 11th, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Dec. 28th, 1914, to Jan. 11th, 1915,  
that I last saw her alive on Jan. 11th, 1915,

and that death occurred on the date stated above, at 6 P. m.  
The CAUSE OF DEATH\* was as follows:

Apoplexy(Duration) yrs. mos. 14 ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) John S. Ziegler, M. D.  
Jan. 13th, 1915 (Address) Manchester, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Manchester Cemetery, January 16, 1915

DATE OF BURIAL

## 20 UNDERTAKER

Jaes H. Kink, 1920 Manchester

ADDRESS

Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marnans," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Carroll 28

485

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City Sykesville (No. Springfield Park Hospital Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Manie Chapiro

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

## 6 DATE OF BIRTH

Unknown, 1868  
(Month) (Day) (Year)

## 7 AGE

47 yrs.

mos.

ds.

If LESS than  
1 day,.....hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

Housewife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Russia

## PARENTS

## 10 NAME OF FATHER

Robert Zadatkowicz

## 11 BIRTHPLACE OF FATHER

(State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER

(State or country)

Russia

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Sykesville, Md.

15

Filed 1-12, 19152 W. Whitter  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

January 12, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Jan. 3, 1914, to January 12, 1915,that I last saw him alive on January 11, 1915,and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH\* was as follows:

Tuberculosis(Duration) Unknown mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Glazebrook, M. D.Jan. 12, 1915 (Address) Sykesville, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 9 mos. 9 ds. In the State 9 yrs. 0 mos. 0 ds.Where was disease contracted, If not at place of death? Unknown.Former or usual residence Baltimore, City, Md.

## 19 PLACE OF BURIAL OR REMOVAL

Baltimore City Jan. 12, 1915

## 20 UNDERTAKER

May L. Lewison & Sons Baltimore, Md.

## DATE OF BURIAL

## ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Gastric*.

**oma**, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traenia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Carroll

486

79

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 53

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Gamber (No. \_\_\_\_\_)

## 2 FULL NAME

Christiana Shifley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Female WhiteMARRIED

6 DATE OF BIRTH

July 24, 1848

(Month)

(Day)

(Year)

7 AGE

66 yrs. 6 mos. 7 ds.If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.at home(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHERChristian Knecht11 BIRTHPLACE  
OF FATHER

(State or country)

Germantown12 MAIDEN NAME  
OF MOTHERMargaret L. Turner13 BIRTHPLACE  
OF MOTHER

(State or country)

Germantown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Shifley

(Address)

Gamber

15

Filed Feb 1, 1915 by J. Lester

REGISTRAR

(1) If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 31, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Dec 20 to 1914 to Jan 31st, 1915that I last saw her alive on Jan. 25, 1915  
and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH\* was as follows:

Valvular Insufficiencyseveral (Duration)  yrs.      mos.      ds.Contributory Chronic Colitis  
Secondary(Signed) Chas. R. Foster, M. D.  
Jan 31, 1915 (Address) Westminster\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place of death  yrs.      mos.      ds. In the State  yrs.      mos.      ds.Where was disease contracted,  
if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

GamberDATE OF BURIAL  
Feb 3, 1915

20 UNDERTAKER

Frank C. Shaffer Westminster  
ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., or..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contribution." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 5 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

487

County CarrollSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 80Village or City New Windsor, MarylandSt. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Mary Cora Smith

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)
6 DATE OF BIRTH <u>May 12</u>		1853 (Month) (Day) (Year)
7 AGE <u>61 yrs. 7 mos. 14 ds.</u>		It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION <u>None</u>	
(a) Trade, profession, or particular kind of work <u>None</u>	
(b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>	

9 BIRTHPLACE (State or country) <u>Carroll</u>	
10 NAME OF FATHER <u>A. Augustus Morris</u>	
11 BIRTHPLACE OF FATHER (State or country) <u>Carroll</u>	
12 MAIDEN NAME OF MOTHER <u>Martha Elizabeth</u>	
13 BIRTHPLACE OF MOTHER (State or country) <u>Frederick Co</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (informant) <u>J. Walter Englar</u>	
(Address) <u>New Windsor, Md</u>	

15 Filed <u>Jan 9, 1915</u> J. Edward West Local REGISTRAR	
---	--

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 6, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1914, to Jan 6, 1915,  
that I last saw her alive on Jan 6, 1915,  
and that death occurred on the date stated above, at 4 P.M.  
The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage with Paralysis —  
(Duration) 1 yrs. 3 mos. 0 ds.

Contributory (Secondary)  
(Duration) 60 hours yrs. mos. ds.  
(Signed) Jan 9, 1915 (Address) New Windsor, Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL Jan 9, 1915  
20 UNDERTAKER J. Edward West ADDRESS 78 Barkhurst St., Westminster

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcinoma*, *Surcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic trilobular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Muscles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**

FEB 2 1915

BURKAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County Carroll 488  
79

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City Sykesville(No. Springfield State Hosp, Sp, Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Marion K Snyder

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Sing</u> (Write the word)
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6 DATE OF BIRTH <u>unknown</u>	(Month)	(Day)	(Year)
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7 AGE <u>23</u> yrs. — mos. — ds.	if LESS than 1 day, _____ hrs. OR _____ milo. ?
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8 OCCUPATION <u>none</u>	9 BIRTHPLACE <u>Md</u>
--------------------------	------------------------

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

10 NAME OF FATHER <u>Geo Snyder</u>
-------------------------------------

11 BIRTHPLACE OF FATHER <u>Md</u>
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12 MAIDEN NAME OF MOTHER <u>Wilhelmina Neumann</u>
--

13 BIRTHPLACE OF MOTHER <u>Md</u>
-----------------------------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
--

(Informant) Hospital Records  
(Address) Sykesville Md

15 Filed Jan 7, 1915 — W. A. Whitten  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 6, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 3, 1913, to Jan 6, 1915,that I last saw him alive on Jan 5, 1915,and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH\* was as follows:

Cardiac dilatation

(Duration) — yrs. — mos. — ds.

Contributory Myocarditis & epilepsy  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) H. W. Anderson, M. D.1-6 —, 1915 (Address) Sykesville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place from Aug 11, 1909 to 1/6/15 — In the For life  
of death yrs. — mos. — ds. State yrs. — mos. — ds.Where was disease contracted, if not at place of death? Baltimore MdFormer or usual residence Baltimore Md19 PLACE OF BURIAL OR REMOVAL Post Office Md DATE OF BURIAL Jan 7, 191520 UNDERTAKER Gas T. Weer ADDRESS Sykesville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Athenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *Spasis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carrol

489

Village or City Union Bridge2 FULL NAME Eliza Tozer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
---------------------	------------------------------	--

6 DATE OF BIRTH

Nov 15, 1846  
(Month) (Day) (Year)

7 AGE

68 yrs. 8 mos. 1 ds. OR min.?11 LESS than  
1 day, .... hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work House wife  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Maryland

10 NAME OF FATHER

David Neodemus11 BIRTHPLACE OF FATHER  
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Eliza Bassell13 BIRTHPLACE OF MOTHER  
(State or country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Isaac Tozer

(Address)

Union Bridge

15

Filed 11/18, 191Leslie Q. Repp  
Deputy RegistrarSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 81

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St. Ward

H. E.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1, 16, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1914, to Jan. 16, 1915, that I last saw her alive on Jan. 15, 1915, and that death occurred on the date stated above, at 9 P. m. The CAUSE OF DEATH\* was as follows:

Chronic ulceration of bowels(Duration) 1 yrs. 0 mos. 0 ds.Contributory  
(Secondary)(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

Jas Watt, M. D.  
Union Bridge

Jan 16, 1915 (Address)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place Union Bridge yrs. 0 mos. 0 ds. In the Carrol State Carrol yrs. 0 mos. 0 ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Mountain View Cem. Jan 18, 1915

DATE OF BURIAL

20 UNDERTAKER

Frank J. Shriver

ADDRESS

Union Bridge

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Association.]

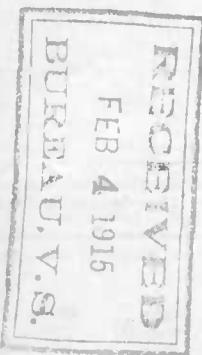
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic catarrhal heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 d.*; *Bronchopneumonia* (secondary), *10 d.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *esophis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

490

County Carroll (28)Village or City Finksburg (No.)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 73

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Edward E Valentine

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
-------------------	------------------------------	--

6 DATE OF BIRTH <u>Jan 5</u>	(Month)	(Day)	(Year) <u>1870</u>
------------------------------	---------	-------	--------------------

7 AGE <u>44</u>	yrs. <u>6</u>	mos. <u>28</u>	ds. <u>0</u>	If LESS than 1 day, _____.hrs. OR _____.min. ?
-----------------	---------------	----------------	--------------	--

8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Farmer</u>
--

9 BIRTHPLACE (State or country) <u>Maryland</u>
--

10 NAME OF FATHER <u>Carroll Valentine</u>
--

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
---

12 MAIDEN NAME OF MOTHER <u>Adella Pickett</u>
--

13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>
---

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Annie Valentine</u>
--

(Address) <u>Finksburg</u>
----------------------------

15 Filed <u>Jan 4 1916</u> by <u>J. L. Lister</u>
---

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 3 (Month) 1916 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1915, to Jan 2, 1916,

that I last saw him alive on Jan 2, 1916,

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH\* was as follows:

Hemorrhage from  
the Lungs - Tuberculosis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) W. L. B. (Duration) yrs. mos. ds.

Jan 4, 1916 (Address) Westminster M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sanctuaryville DATE OF BURIAL Jan 5, 1916

20 UNDERTAKER Frank C. Sharpen ADDRESS Westminster

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED
FEB 3 1915
BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

491

151

County Carroll

134

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 77

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Manchester (No. \_\_\_\_\_)

## 2 FULL NAME

Lawrence Henry Walker

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

## 6 DATE OF BIRTH

Jan 29, 1915  
(Month) (Day) (Year)

## 7 AGE

yrs. .... mos. .... ds. If LESS than  
 f day, .... hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Carroll Co. Md

## 10 NAME OF FATHER

Henry A. WalkerYork Co. Pa.11 BIRTHPLACE OF FATHER  
(State or country)Sadie M. Shearer

## 12 MAIDEN NAME OF MOTHER

Carroll Co. MdErwin F. AlbanHampstead77 S. Main StreetREGISTRARFeb 1, 191577 S. Main StreetREGISTRARFeb 1, 1915REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 30, 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH\* was as follows:

Premature Birth—possibly  
7 mo. child

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) J H Sherman, M. D.

Jan 31, 1915 (Address) Manchester Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Grace Room DATE OF BURIAL  
Feb 2, 1915

20 UNDERTAKER ADDRESS

Theo F. Shearer Manchester Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laboner," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ictius*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Carroll md

(43)

Village or City 6th Dist (No. Manchester)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 75St. P Ward 7

If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Catharine Wildasin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
---------------------	------------------------------	--

## 6 DATE OF BIRTH

Oct 26, 1838  
(Month) (Day) (Year)

## 7 AGE

76 yrs. 2 mos. 6 ds. If LESS than  
1 day, hrs. OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

House Wife9 BIRTHPLACE  
(State or country)

Pa

John Rost

11 BIRTHPLACE  
OF FATHER  
(State or country)

Germany

Catharine Reinhardt

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Pa

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Catharine Wildasin

Limestone md

15

Filed 1/3, 1915J. P. Baltazar  
Local Registrar

If more blanks are needed, address State Registrar, 8 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 2, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Apr., 1914, to Jan 2, 1915,

that I last saw her alive on Jan 2, 1915.

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of the Breast

(Duration) 5 yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. D. Danner, M.D.Jan 3, 1915, (Address) Glenville Pa

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death? State yrs. mos. ds.

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

St. Jacobs Church Cemetery Jan 5, 191520 UNDERTAKER Bork Co. Pa

G. F. W. Miller

ADDRESS

Glenville Pa

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

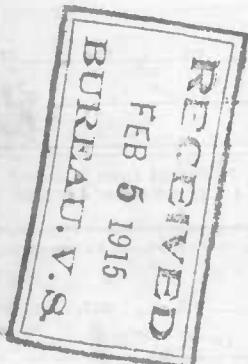
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cercospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Oncer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anthenis," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Carroll

493

1134

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 76Village or City Westminster (No.)UnionSt. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emma Woodard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH

(Month) 1873 (Day) (Year)

7 AGE

42 yrs. — mos. — ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Jan 6, 1915EW Brown

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 9, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug. 1914 to Jan 9, 1915  
that I last saw her alive on Jan 7, 1915and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia of Lecture(Duration) yrs. 7 mos. — ds.Contributory Festering (Secondary) Syphilis(Duration) yrs. 5 mos. — ds.(Signed) Albert B. Bar, M.D.Jan 9, 1915 (Address) Westminster, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Gates Chapel DATE OF BURIAL Jan 12, 1915

20 UNDERTAKER

Bankard Son ADDRESS Westminster

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrosupinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Grupe"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*oma, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Can-*cer*" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ast-*henia*," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-*genital*," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-*mus*," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicar-*mia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIO-*LENT DEATHS* state MEANS OF INJURY and QUALITY AS ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory". (Recommendations on statement of cause of death approved by Committee on Nomencla-ture of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

494

County Carroll.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 77

Village or City Hampstead, (No.)

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Calvin Woolery,

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male.	4 COLOR OR RACE White.	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married.
-------------	------------------------	--

## 6 DATE OF BIRTH

Unknown. Unknown, 1844  
(Month) (Day) (Year)

7 AGE 71 yrs. 4 mos. 11 ds.	If LESS than 1 day, hrs. OR min. ?
-----------------------------	------------------------------------

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work **Laborer.**  
 (b) General nature of Industry, business, or establishment in which employed (or employer) **022**

9 BIRTHPLACE  
(State or country) Maryland.

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER  
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Sallie Richards,

13 BIRTHPLACE OF MOTHER  
(State or country) Maryland.14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **McElroy Harris Jr.**(Address) **Hampstead, Md.**15 Filed Jan 3, 1915 **M. A. Abbott**

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1, 2, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1914, to Jan. 2, 1915,

that I last saw him alive on Jan. 2, 1915,

and that death occurred on the date stated above, at 8, P. m.

The CAUSE OF DEATH\* was as follows:  
**Lobar Pneumonia,**(Duration) yrs. mos. 7 ds.  
Contributory **Heart Failure.**  
Secondary(Duration) yrs. mos. ds.  
(Signed) **Edgar M. Bush**, M. D.  
1/2, 1915 (Address) **Hampstead, Md.**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL **St. John's Church** DATE OF BURIAL **1-4, 1915**20 UNDERTAKER **C. C. Johnson** ADDRESS **Hampstead, Md.**

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masculitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 2 1915

BUREAU, U. S.

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495

**1 PLACE OF DEATH** County Carroll 91  
Village Pleasant Valley

**2 FULL NAME** Barbara Yingling

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** Female **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Widowed  
(Write the word)

**6 DATE OF BIRTH** July 4, 1878  
(Month) (Day) (Year)

**7 AGE** 87 yrs. 7 mos. 20 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

**8 OCCUPATION** None  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer) 000

**9 BIRTHPLACE** (State or country) Carroll Co. Md.

**10 NAME OF FATHER** Peter Bittle

**11 BIRTHPLACE OF FATHER** (State or country) Carroll Co. Md.

**12 MAIDEN NAME OF MOTHER** Barthamie Young

**13 BIRTHPLACE OF MOTHER** (State or country) Carroll Co. Md.

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) Fred Yingling  
(Address) Westminster Md.

**15** Filed 191

**REGISTRAR**

**STATE OF MARYLAND**  
**CERTIFICATE OF DEATH**

Registration Dist. No. 71

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**16 DATE OF DEATH** Jan. 24, 1915  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1915 to Jan 24, 1915, that I last saw her alive on Jan 23, 1915 and that death occurred on the date stated above, at 12.30 m. The CAUSE OF DEATH\* was as follows:

Bronchitis Pneumonia (Duration) yrs. 4 ds.  
Contributory (Secondary) Bronchitis (Duration) mos. 15 ds.  
(Signed) J. Lewis Westel, M.D.  
Jan. 26, 1915 (Address) Union Mills Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**  
At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence.

**19 PLACE OF BURIAL OR REMOVAL** Silver Run Rd. **DATE OF BURIAL** Jan. 27, 1915

**20 UNDERTAKER** Edw. F. Groft **ADDRESS** Union Mills Md.

If more blanks are needed, address State Registrar, c/o Franklin St., Balt., Requesting V. S. No. 11

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

ASSOCIATION.

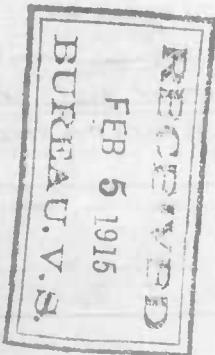
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an

additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

oma, Sarcoma, etc., of ~~.....~~ (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accidental; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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Statement or cause of death.—Name, first, the **disease** causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*



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1 PLACE OF DEATH  
County Carroll 496  
Village or City Westminster (No. 79)

2 FULL NAME Martie Gauer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>
6 DATE OF BIRTH		(Month) <u>1</u> (Day) <u>1</u> (Year)
7 AGE <u>about 65</u>		If LESS than 1 day, hrs. <u>0</u> ds. <u>0</u> min. <u>0</u>
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u>		(b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>
9 BIRTHPLACE (State or country) <u>Smitsgerland</u>		
10 NAME OF FATHER <u>Walter Brown</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>11</u>		<u>11</u>
12 MAIDEN NAME OF MOTHER <u>11</u>		<u>11</u>
13 BIRTHPLACE OF MOTHER (State or country) <u>11</u>		<u>11</u>
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Augustas Humbert</u> (Address) <u>Westminster Md</u>		
15 Filed <u>Feb 2<sup>nd</sup> 1915</u>	E. W. Shriver	REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 76

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St. Ward

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 30, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from Jan 1, 1915, to Jan 30, 1915.that I last saw him alive on Jan 23, 1915.and that death occurred on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH\* was as follows:

Acute cardiac dilatation  
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory Chloroform gas intoxication  
(Secondary) 3 yrs. 0 mos. 0 ds.

(Signed) Henry W. Shriver, M. D.  
2-2, 1915 (Address) Westminster Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 11 yrs. 0 mos. 0 ds. In the State 11 yrs. 0 mos. 0 ds.Where was disease contracted, if not at place of death? 11Former or usual residence 1119 PLACE OF BURIAL OR REMOVAL County Cemetery DATE OF BURIAL Feb 2, 191520 UNDERTAKER James M. Stover ADDRESS Westminster Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

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**RECEIVED**  
FEB 6 1915  
BUREAU, U. S.

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oma. *Sarcoma*, etc. of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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